Vision Service Plan
Employee Application

1. Enrollment Status

- ❑ New Group Enrollment
- ❑ New Hire Enrollment
- ❑ Family Addition (Date of marriage, birth or adoption _______________)
- ❑ COBRA (Effective date ___________________________________)

2. Employee Information

Last Name		First Name		Middle Initial
Social Security Number		Hours Worked per Week		
Marital Status	❑ Single ❑ Widowed	❑ Married ❑ Divorced	Number of Children	
Home Street Address (P.O. Box not acceptable, unless Rural P.O. Box)				Apt. Number
City	State	ZIP	Home Phone	
Company Name		Job Title		
Business Phone		Date of Hire		

3. Member Information:

An eligible dependent is an employee's spouse, the unmarried children under age 19 of the employee or the enrolled spouse, the unmarried children of the employee or enrolled spouse who are ages 19-24, full-time student, and fully dependent children upon the employee for support. Enrollment on this plan is determined by the employer's participation selection.

Last Name	First Name	M.I	Birthdate	Covered by employer's Group Medical Policy?
❑ Male Employee ❑ Female				❑ Yes ❑ No
❑ Male Spouse ❑ Female				❑ Yes ❑ No
❑ Son ❑ Daughter				❑ Yes ❑ No
❑ Son ❑ Daughter				❑ Yes ❑ No
❑ Son ❑ Daughter				❑ Yes ❑ No

(over)

4. Authorization:

(The following authorization section must be signed by the employee applying for coverage.)

I understand that my employer is applying for membership in the Supplemental Vision Benefit Employer Trust (the "Trust") and I am simultaneously applying for insurance for which I am now or may be eligible for under the provisions of the Vision Benefit Plan issued to that Trust by Vision Service Plan. I understand that my insurance will not be in force until the application is approved by Vision Service Plan or their authorized Administrator in accordance with the underwriting guidelines in effect. I understand that acceptance of the check submitted with the application does not constitute approval or guarantee of coverage.

I understand that some of the contracts Warner Pacific Insurance Services, Inc. ("Warner Pacific") holds with insurance carriers allow incentives, bonuses and excess surplus compensation ("compensation"). In the sole and exclusive discretion of Warner Pacific, such compensation may be retained by Warner Pacific or paid to other parties. Such compensation will not be returned to you or your dependents. Any vision benefits claims submitted under your policy/certificate will be paid without regard to such compensation.

I agree that all information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Beneficial Administration Company and/or Vision Service Plan.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. I, the applicant, acknowledge that I have read and understand this application in its entirety.

Signature of Employee: ___________________________________ Date: ________________